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Executive Development

Developing a Standard Operating Procedure for City of New York Fire Department EMS: Processing and Review of Scannable Patient Care Reports

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October 2004

CERTIFICATION STATEMENT

I hereby certify that this paper constitutes my own product, that where the language of others is set forth, quotation marks so indicate, and that appropriate credit is given where I have used the language, ideas, expressions, or writings of another.

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Abstract

The City of New York Fire Department (FDNY) is implementing a new scannable patient care report (ePCR), however it did not have a procedure in place for the review and processing of this new system. The problem was that the Health Insurance Portability and Accountability Act (HIPPA) regulations mandate a processing and review procedure is in place, and the department is compliant with its procedure. Rules governing proper documentation for revenue collection as set by the Centers for Medicare and Medicaid Services (CMS) also needed to be included regarding proper documentation for revenue collection. The research purpose was to develop a FDNY Emergency Medical Services (EMS) Standard Operating Procedure (SOP) for the processing and review of its new ePCR. Descriptive research methodologies were employed to answer the following questions:

1. What are the HIPAA and CMS regulations dealing with patient care report processing, review and compliance for the ambulance provider agency?
2. What processing and review procedures are in place by other departments currently using the HealthEMS ePCR system?
3. What components of the patient care report processing and review procedure of the current FDNY paper system will be applicable to the new system?
4. What types of data reports can be extrapolated from the ePCR system and how can these reports be incorporated into the processing and review policy?

The procedures included literature review, personal observations of end-user focus groups, and interviews with representatives of other EMS agencies using the same ePCR system. The results provided a user friendly SOP. It was recommended to use continuous quality improvement to update the policy as necessary.

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Developing a Standard Operating Procedure for City of New York Fire Department EMS: Processing and Review of Electronic Scannable Patient Care Reports

The City of New York Fire Department (FDNY) is implementing a new scannable patient care report (ePCR) system for recording and electronically storing the data, however it does not have a procedure in place for the review and processing of this new system. The problem is that the Health Insurance Portability and Accountability Act (HIPPA) regulations mandate that a processing procedure be in place and the department conduct reviews to ensure compliance with its procedure. The policy also needed to cover the rules set by the Centers for Medicare and Medicaid Services (CMS) regarding proper documentation for revenue collection.

The research purpose is to develop a FDNY Emergency Medical Services (EMS) Standard Operating Procedure (SOP) for the processing and review of its new ePCR that is compliant with HIPAA and CMS regulations. Descriptive research methodologies were employed to answer the following questions:

1. What are the HIPAA and CMS regulations dealing with patient care report processing, review and compliance for the ambulance provider agency?
2. What processing and review procedures are in place by other departments currently using the HealthEMS ePCR system?
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Background and Significance

The FDNY EMS is made up of over 3000 employees, and processes approximately 700,000 patient care reports each year. The patient care report utilized was a paper form that was processed manually. In order to ensure HIPAA and CMS compliance, each of those forms were reviewed individually by a field supervisor, a division patient care report coordinator and a division Advanced Life Support (ALS) coordinator for policy compliance. After field review, the forms were sent to the patient care report unit where the forms were reviewed again, and the information was manually entered into a database for billing. The entire process took over six weeks to complete.

The FDNY began to examine different types of electronic patient care reporting technology that was available in order to become more efficient, provide cost savings, enhance compliance and increase ambulance billing revenue. This electronic reporting would also fulfill the HIPAA requirement for electronic claim filing. The decision was made to utilize the HealthEMS system, a product of ScanHealth Incorporated of Duluth, Minnesota. The system utilizes scannable paper forms upon which EMS personnel print pertinent information about patient identification, evaluation, treatment and transportation. These forms are then scanned using ordinary optical scanners attached to a desktop PC with an intranet connection. The system uses character recognition software to interpret the handwriting in pre-defined blocks, and creates a data set of required information via the scanalyzer program. This information is then uploaded via the FDNY intranet connection to the data server. In addition, an optical image of the scanned form is uploaded and stored. Immediately after the upload, both the data and the optical image are available for query, analysis, and retrieval (Fitch and Associates, LLC, 2001). This data is also linked to the Computer Aided Dispatch (CAD) system, which verifies a patient care report was generated for any call with a patient contact disposition.

While there is an existing SOP for the processing and review of the current paper form patient care report, the changes with the new system meant the policy required updating to reflect the

new technology that would be available at all levels of the process. Because of the HIPAA regulations that warrant compliance with the policy and the CMS rules regarding billing, it is important to have a procedure that is easy to understand and user friendly.

The previous policy and form utilized in the patient care report system, was revised five times over the last four years in an attempt to reduce errors and omissions. This resulted in better documentation for increased revenue and reduced non-compliance.

Initiating this new patient care report system will pose a challenge for introducing new technology to the field. A simple to follow policy will assist the personnel through the transition and further increase the compliance necessary to increase ambulance-billing revenue.

The Executive Development course of the National Fire Academy's Executive Fire Officer Program is intended to prepare the fire service executive for the 21st century by training the leader as learner, one who can anticipate future trends (USFA National Fire Academy, 2004, iii). The effective use of teams (i.e. focus groups) as discussed in Module 2 and change management in Module 4, will result in a user-friendly policy compliant with HIPAA and CMS. While observing these teams at work, I needed to "get on the balcony" (Heifetz & Linsky, 2002, 55) in order to distinguish technical from adaptive challenges. Utilizing the end-user focus groups would address the adaptive challenge by involving each level of the FDNY EMS in the development of the policy. This would result in buy-in from the field personnel. The technical challenges would be identified and covered through training and the SOP.

My research will examine literature resources regarding HIPAA and CMS regulations, and the utilization of focus groups. The purpose of these focus groups will be to identify end user objectives that need to be addressed in the new procedure, by using a demonstration system and reviewing the data reports available. These objectives and the HIPAA and CMS regulations will be compared against the current FDNY patient care report procedure to examine what items from that procedure are still applicable to the new system. I will also conduct interviews of current

users of the ePCR system from other EMS agencies and examine their processing and review policies. Information from these resources will be used in outlining objectives to be covered in our own policy.

Literature Review

A literature review was conducted to provide a summary of findings of others as it relates to HIPAA laws and CMS rules governing ambulance services. The review would also provide perspectives from other EMS agencies regarding potential problems and solutions in formulating a policy for the ePCR system. In addition, literature regarding the team approach to problem solving and utilization of focus groups was conducted.

HIPAA and CMS

The most challenging of the HIPAA rules to be followed is the Privacy Rule, which became mandatory on April 14, 2003. Ambulance services are considered a covered entity under the rule because they bill and process claims electronically. This means that all medical records or patient identifiable health information (PHI) processed by the ambulance service, whether electronic, paper or orally transmitted, are covered by the Privacy Rule. HIPAA will enforce strict standards for the electronic submission of patient information (Charkin, 2002, 6).

The two broadest and most important rights given under the HIPAA rule are the right to notice and the right to consent (Page, Wolfberg, & Wirth, 2001, 15). This means that the FDNY has the responsibility to develop and implement a Notice form to ensure the patient is given proper notice of his or her rights. In addition, ambulance providers must obtain the patient's consent prior to using or disclosing PHI to carry out treatment, payment or health care operations (New York State Department of Health [NYSDOH], 2002).

On April 1, 2002, the CMS based its definition of an emergency on the condition of the patient at the time of dispatch. Proper documentation by ambulance crews can result in revenue generating non-emergency transports(Wolfberg, 2003, 2). However, under the current federal

laws, only the agency which transports the patient to the hospital can receive reimbursement (Ludwig, 1999, 28).

The CMS is developing close to one-hundred condition codes, each of which describes a certain medical condition with which an EMS provider might be confronted. This was predicated on the basis that emergency medical technicians and paramedics do not have the necessary training or tools to make a diagnosis. It is the condition of the patient at the time of transport that determines whether the transport and services are payable under Medicare ambulance benefits (Best Practices in Emergency Services, 2003, 92). Medicare also has a long-standing policy that mileage is covered only to the nearest appropriate facility (Best Practices in Emergency Services, 2002, 142).

A clearly defined policy is paramount in executing successful organizational change (Carter, 1994, 22). A workable policy needs to begin with a clear identification of the objectives to be obtained by the end users. The use of teams (Pokras, 1995) can then be used to systematically reach decisions on making the policy user friendly. Arthur Andersen (Andersen, 1998, 85) discusses the importance of understanding the wants and needs of customers (end-users) and involving them in the design of products and services. A user-friendly policy coupled with incorporating the new technology available, can result in enhanced service delivery to the community (Heckerson, 1998, 50).

The FDNY EMS Command Operating Guide Procedure 102-15 Preparation and Review of Ambulance Call Reports (2002) provides a step by step instructional guide for completing the paper system patient care report. This procedure was developed over a five-year period, with changes and updates added to improve patient care report documentation. Accurate and complete patient care reports are necessary in order to collect revenue or be able to appeal any denied claims (Charkin, 2002, 6). Any new policy should be flexible and allow for modification

or simplification as you learn more about compliance with the new HIPAA regulations (Drinkwater, 2003, 58).

Wolfberg (2001) discusses the legal obligation to ensure the integrity and confidentiality of patient care reports. A patient care report can be corrected, appended and modified, provided the changes are clearly reflected with the initials, date and time of the person making the change. Scott (2001) emphasizes the importance of the initial data collection by the field staff and the proper audits of the data by supervisors, continuous feedback from the billing and compliance units, proper documentation of patient's medical conditions, and a process in place for obtaining patient consent to bill third-party payers.

Interviews

Three interviews were conducted with representatives from EMS agencies that are already using the HealthEMS ePCR system. It was important to learn from the information they were able to provide regarding the challenges and successes they encountered with the system, and changes or procedures they implemented to improve system quality. I would be able to use that information in identifying objectives that needed to be addressed in our SOP.

Chief Bruce Baxter is the Chief of Service for New Britain EMS in Connecticut. His department has 65 employees that use the Health EMS ePCR system on approximately 12,000 ambulance runs per year. His department has been using the system for approximately two years, and states that the policy is a continual work in progress. When the system was first introduced to his department, the personnel completed, scanned and validated their own forms using the scanalyzer program. However, due to numerous inconsistencies between crew members in using the system, the scanalyzer program functions are now handled by two clerical staff who have become proficient in the program. He suggested that if our department was going to use each crew member to scan and validate their own forms, that a comprehensive step by step policy be written to eliminate confusion and provide clear guidance; including maintenance of

the scanner and software by cleaning the scanner daily and deleting excess ITF files. He also discussed his department's policy which restricts the clerical validators from making any changes to the patient care report data fields except in the patient billing information section, where there were common spelling and numerical mistakes.

The supervisors review all ePCRs for proper completion of the form at the end of each shift, before being submitted for scanning and validation. The supervisors also utilize the review queries to identify deficient trends in patient care and documentation, and propose a plan for improvement. They are also supplied with a monthly compliance report and continuous feedback from their billing department to utilize in developing plans to educate crews and reduce risk.

Darel Raddle is Director of Ambulance Service at Ridgeview Medical Center in Waconia, Minnesota. Their department has over 64 employees that use the HealthEMS ePCR system. He has developed a policy to identify when a patient care report needs to be completed, and when doing so to treat the information as confidential. The policy also outlines the time frame for turning in the completed reports by the end of shift. His department did not provide a SOP for how to fill the form out. They covered that material during a training orientation session in conjunction with the Medicare code book as a reference.

Paramedic Craig Smith is the Performance Improvement and Quality Manager for North Shore – Long Island Jewish Health System Center for Emergency Medical Services, located in Lake Success, New York. His department does not have any written policy governing the use of the HealthEMS ePCR. Direction is given to the employees during orientation, and quality improvement verbal feedback is provided on an on-going basis. This method has improved their compliance and documentation since the program's inception.

All three of the interview subjects also discussed the different types of reports they can obtain from the system which has a positive impact on their quality assurance (QA) and quality improvement (QI) programs. Each agency used some type of storage containers to keep the

ePCRs flat and clean. The length of time for keeping the paper copy of the form after scanning ranged from one to seven years in long term storage before being shredded. For the short term, the forms were kept at the stations for thirty to ninety days.

Procedures

Interviews

Representatives from three different EMS agencies who were using the HeathEMS ePCR system, were interviewed between August 31 and September 23, 2004. I developed eleven open-ended questions for each interview subject to answer. These questions were forwarded and responded to via e-mail and then followed up with a telephone interview to discuss their responses in detail. The phone interviews took place at Fire Department Headquarters in Brooklyn and the EMS Division 4 office in Queens. The questions asked during the interview were as follows:

1. Does your organization have any written policies for the processing and review of the HealthEMS ePCR system?
2. How many employees in your organization utilize the ePCR in the “911” system?
3. Approximately how many ePCRs are turned in per month?
4. What role does the supervisor play in reviewing the ePCRs, if any?
5. How is QA/QI conducted based on the retrievable data from the ePCR?
6. How are ePCRs stored in the ambulance between calls?
7. How do you store ePCRs and how long do you save the paper copy?
8. Does the validator of your ePCRs have the ability to change improper codes listed by the crew on the ePCRs to a more appropriate code, if evidence can be found in the narrative section or other areas of the ePCR?

9. After using the system for a while, what proactive procedures have you put in place, to improve billing and compliance?
10. After the expected learning curve in utilizing the new forms, what are the most common problems you find with the crews using the ePCR system?
11. What is the official name of your organization and your official title?

Personal Observations

An end-user focus group was put together using field personnel at each level who would be utilizing the ePCR system. The first three divisions scheduled to go on-line with the system, were identified to participate in the focus group. The personnel were chosen by the Division Commanders from EMS Division 1 (Manhattan), EMS Division 2 (North Bronx) and EMS Division 3 (South Bronx and Harlem). They were instructed to choose one Emergency Medical Technician (EMT), one Paramedic, one Lieutenant and one Captain. It was requested that their choices include a combination of personnel who were documented as being proficient in patient care documentation and personnel who were documented as making numerous errors with the existing process. Patient care report performance is documented by the commanding officers at each station, during their monthly audits. The purpose behind these choices was to get a well-rounded representation of the personnel who would need to understand the process and new SOP for the ePCR system.

A demonstration set-up of the HealthEMS ePCR system was assembled in the computer lab classroom at FDNY headquarters in Brooklyn, New York. A four-day end-user group session occurred there from June 21 – June 24, 2004. The first day consisted of a training session in how to complete the new ePCR form, scan it, upload it and validate it using the scanalyzer program. The training included both didactic and practical components and was conducted by Tom O'Neill of the HealthEMS corporation.

The second day, the participants were broken up into three separate groups. The first group consisted of field EMTs and Paramedics who would utilize the system in their daily operation of

providing patient care and documentation. The second group consisted of the Advanced Life Support (ALS) coordinators, who review the ALS patient care reports for protocol compliance and continuous quality improvement regarding ALS care. The third group consisted of the front line supervisors, lieutenants and captains, who review patient care reports for completeness and compliance.

During the next two day period, the following procedures would be observed and the results recorded on the observation data collection sheet (Appendix A):

1. The ease or difficulties encountered by the EMTs and Paramedics in completing the new ePCR form.
2. The ease or difficulties in processing and validating the forms with the scanalyzer system.
3. The ease or difficulties encountered by the Paramedics in programming the Lifepak 12 and the downloading of the electrocardiogram (EKG) data.
4. A determination of which query reports available would be beneficial to the ALS coordinators in conducting their patient care report audits and continuous quality improvement for protocol compliance.
5. A determination of which query reports available would be beneficial to the front line supervisors in conducting their patient care report audits for HIPAA and CMS compliance.

Behaviors observed in each work group, would identify any areas of the system that were problematic and required more specific direction besides generalized training. These areas could be addressed in the SOP to provide a consistent reference.

On the fourth day, an organized discussion with each group was conducted to examine which parts of the current patient care report SOP would still be applicable, and establish a list of additional items that required instruction in the new SOP.

Following this end-user focus group session, an initial draft of the ePCR SOP was created. This initial draft was utilized when the first phase of the ePCR system was activated at three

stations in Manhattan. Battalion 4 (Lower East Side Station) went on-line August 3, 2004, Battalion 8 (Kips Bay Station) went on-line August 17, 2004, and Battalion 10 (Yorkville Station) went on-line August 27, 2004.

After implementation of the ePCR system at the initial three stations in Manhattan, meetings and correspondence were conducted on a regular basis with the compliance and billing departments of FDNY. The information gathered from these departments as a result of compliance audits, identified additional items requiring procedural instructions in order to increase the overall compliance performance. This resulted in the latest draft version of the SOP for processing and review of the ePCR (Appendix B).

Limitations

FDNY EMS is the largest pre-hospital care provider in the world, and there were no other EMS agencies close in size who were utilizing the HealthEMS ePCR system. This limited my information gathering from small sized agencies that would not necessarily apply to a large department. In addition, these agencies have designated one or two individuals to operate the scanalyzer program for all ePCRs. The FDNY system was designed for each crew member to validate their own ePCRS by using the scanalyzer program.

The SOP for the processing and review of ePCRs is submitted in its latest draft stage. There are numerous areas of responsibility within the FDNY who need to review and approve the final version of any SOP. This process in its entirety exceeds the time allotted for this project.

Results

1. What are the HIPAA and CMS regulations dealing with patient care report processing, review and compliance for the ambulance provider agency?

The literature review identified a number of regulations that pertain specifically to ambulance provider agencies. The HIPAA privacy rule is the most involved mandate. The ambulance service provider has a responsibility to notify the patient of their rights regarding the release of

their identifiable health information (PIH) and obtain their consent to provide treatment and forward that information to their health insurance company or Medicare. HIPAA recommends that a notice form be developed for patient distribution and an area be designated on the patient care form for the patient's signature authorizing release of that information.

The patient's health information privacy also needs to be protected at all levels of the patient care report processing. This includes the data collection, form storage and electronic submission of information for billing purposes.

The CMS regulations for processing and payment on claims are based on proper patient care report documentation and billing department coding. This includes mileage, appropriate facility where the patient is transported, the patient condition at time of dispatch and transport, and the type of assessment and treatment provided. The patient condition needs to be coded according to the CMS medical condition codes.

Observations and discussions with the end-user group revealed that the personnel were unclear in the purpose of obtaining a patient signature on the current patient care report. In addition, they were confused by the patient presenting problem and cause of injury sections on the ePCR and tended to code those sections as 55 (other) and 45 (unknown).

2. What processing and review procedures are in place by other departments currently using the HealthEMS ePCR system?

In interviewing the representatives from the three different EMS agencies using the ePCR system, the following responses were provided:

Only one of the organizations interviewed had any written policy regarding the processing of the ePCR system. The policy that existed for that agency, identified that an ePCR form needed to be completed for any patient contact, that all information be treated as confidential and that the form be turned in at the end of shift.

All of the agencies covered the HIPAA and CMS regulations during orientation training, and

provided continuous verbal and written feedback to their employees, to improve compliance. Each of the agencies had one person in particular who audited the forms on a regular basis in order to provide continuous quality improvement.

The size of each agency varied from 64 to 300 employees. The number of ePCRs processed at each agency ranged from 350 per month to 3000 per month.

The supervisor role varied in each agency. The smallest of the three agencies utilized their dispatch supervisor to review the name and address information listed on the billing review report in comparison with the dispatch data. This was done for each patient care report completed and uploaded through the scanalyzer program. The dispatch supervisor made corrections where necessary on the electronic record. The report was then forwarded to the EMS manager for Quality Assurance review of the patient's presenting condition and the treatment provided.

The largest of the three agencies required their supervisors to randomly audit fifty ePCRs per month, prior to uploading and validating the information with the scanalyzer. They were instructed to audit for completeness, and proper patient treatment in conjunction with the patient's presenting condition documented.

The Quality Assurance and Quality Improvement programs at all three agencies were conducted by performing report queries of the ePCR system. They all used a small group of supervisors to track trends in data for use in employee performance reviews and for educational sessions to achieve overall improvement in service.

The ePCR forms were stored in a couple of different ways. One agency stored the forms in a Tupperware type container in order to keep them flat and dry. The others utilized architect type storage tubes and storage compartment clipboards. At the end of the shift, the forms were either turned in to the supervisor on duty or the dispatch center.

Long term storage of the ePCR form varied between agencies. One agency kept their forms

on file by date for one month, prior to sending them to archive storage. Another agency forwarded them each day to a main area where the forms were uploaded and validated and then sent to archive storage. All agencies kept the paper forms archived for one to seven years, but only utilized the electronic data report and scanned image of the ePCR if a copy was requested. Each of the agencies permitted changes to the ePCR electronic data of the form when necessary, specifically issues related to billing or patient presentation codes. One agency allowed the dispatch supervisor or EMS manager to make the changes and another agency sent the form back to the crew to make the necessary corrections. After the corrections were made, they would re-scan and upload the form.

In order to improve their compliance, there were numerous proactive measures put in place after using the ePCR system for a while. It was unanimous between all agencies that the field personnel tended to rush through the validation process of the name and address fields on the form. There also was initial difficulty in the field personnel choosing the correct label for the patient presenting condition. These reasons resulted in the agencies adding an additional layer of ePCR form review prior to forwarding to the billing department. At one agency, software changes were amended to add a comments section for documenting the errors noted and quality improvement actions taken. This comment section was then utilized in the employee performance review. Another agency utilized the supply code section on the form to identify which fifty random ePCR forms were audited and by whom.

The most common problem that each agency found with the ePCR system, was the subjective information regarding provider impression/patient presenting problem. While the providers were able to provide detailed information in the narrative section of the form, they had difficulty in choosing the proper code. One agency also stated, that the paramedics had difficulty in documenting the proper medication and treatment codes to go along with the patient presenting problems code.

Each of the agencies interviewed were hospital or community based ambulance provider services and the representatives of each organization were at the director or quality assurance and quality improvement level.

3. What components of the patient care report processing and review procedure of the current FDNY paper system will be applicable to the new system?

The current SOP provides a step by step method for filling out the patient care report for both FDNY EMS and voluntary hospital units which participate in the New York City 911 system. This new policy will only apply to the FDNY EMS units, and needs to be adjusted in its scope. It combines the practical application with the administrative application including how the reports should be stored and audited. The observations and discussions with the end-user focus groups revealed that the personnel indicated a step by step instruction manual would be a good reference, however, they would prefer to see the manual separated from the administrative procedure itself. They felt it would be easier to locate the information they needed if the two sections were separated.

It was observed that all personnel who participated in the focus group found the form simple to complete. Some of the personnel were computer savvy and grasped the validation program with ease. Some of the participants do not own a computer and took additional time in learning to operate the keyboard and mouse components. However, once they became familiar with the system, they were able to perform the validation function with ease. The immediate feedback process using the scanalyzer validation program, encouraged diligence on their part when writing on the ePCR form.

The most interesting observation was that as the participants became more comfortable with the system, they began to race through the validation process, and uploaded incorrect information. This supported the information supplied by the other EMS agencies who reported similar problems. The discussion on the last day revealed the need to list the series of steps to

cover the scanning, uploading and analyzing phases of processing.

The paramedics also needed to learn how to download their EKG information from the Lifepak 12. While they found the steps relatively easy to perform, they indicated a step by step guide to downloading the EKG would be beneficial to the field personnel.

While some of the items pertaining to compliance are still applicable to the new ePCR system, many of the steps regarding review by supervisors will no longer be pertinent. The supervisors utilized a number of the available reports and demonstrated the ability to review random samplings and specified data on the validated ePCRs. They found the information they obtained in the reports could be utilized to provide guidance to employees in order to improve their performance in achieving compliance.

The ALS coordinators were able to query and review the patient presenting problems and protocol compliance by unit and evaluate critical skill performance documentation by employee. They felt the number of different trends they could track should be left generalized in the procedure with guidelines provided as set by the medical affairs office. The information they collected could then be used to develop continuing medical education sessions.

The ability of the new ePCR system will change the time frame for review and processing of the patient care reports from weeks to days. This would also need to be reflected in the new procedure.

4. What types of data reports can be extrapolated from the ePCR system and how can these reports be incorporated into the processing and review policy?

There are a number of standardized reports that come as part of the package from HealthEMS, and other customized reports that can be developed. The most common reports utilized by the other agencies interviewed include the billing report, mileage report, patient presenting problem report, employee critical skills report, patient signature report and treatments performed summary.

The feedback received from the billing and compliance departments once the system went on-line in Manhattan, indicated field audits were necessary paying particular attention to certain items when reviewing validated ePCRs. This feedback supported some of the items identified by the other agencies interviewed. The most common problems they found were incorrect billing information, such as patient name and address, where the scanalyzer program was recognizing 5 as S, 2 as Z and 1 as I. The other area was gender, which was often left blank and hospital selection. Many of the personnel filled in patient choice as a hospital selection when in fact it fell under the nearest hospital designation. In New York City, any hospital located within a ten minute transportation time from the closest hospital (Ten Minute Rule), should be indicated as the nearest hospital designation. This information led to HealthEMS customizing additional reports for use in the field audits by FDNY EMS supervisors.

Discussion

The HIPAA and CMS regulations pose significant concerns for the ambulance provider agencies when dealing with patient care report processing, review and compliance. Numerous EMS journals and magazines featured articles emphasizing the importance of having a well defined procedure in place when dealing with the patient privacy rules regarding PIH and patient consent (Charkin, 2002; Page Wolfberg and Wirth, 2001). While the agencies interviewed did not have a written policy in place to address this issue, they were able to ensure compliance due to the small size of the agency. I felt that in an agency as large as the FDNY EMS, it was important to spell out the rules in our procedure and provide the reasons behind it. The ePCR form was also customized, to include a detachable copy of the patient information sheet with an explanation of the PHI privacy rule and patient's bill of rights which could be given to the patient. It was found during the end-user focus groups, that many of the field personnel did not understand why they were obtaining a patient signature on the patient care report. Providing an explanation in the procedure would clarify the reasons and direct compliance. The supervisors

were also instructed to perform a report query to ensure the crew was obtaining a patient signature in the patient information disclosure and assignment of claim box.

Each of the EMS agencies interviewed noted problems with personnel understanding the CMS coding guidelines. This was confirmed by FDNY EMS personnel during the end-user focus groups and by field personnel at Battalions 4, 8 and 10 when the ePCR system initially went on line. The procedure for supervisors to query all ePCRs validated with code 55 (other) in the patient presenting problem and code 45 (unknown) in the cause of injury/illness box, was included in order to identify those personnel having difficulty in understanding the Medicare code labeling on the patient care report. This provided the supervisors with a timely feedback mechanism to provide education to the personnel in proper coding and increase billing compliance. The supervisors also liked the ability to electronically document interactions with the crew and any corrections made in the data field comments section.

After receiving feedback from the billing and compliance departments within FDNY, additional query reports were added to confirm name, address, gender, and hospital selection choice. The other agencies also indicated problems with the field personnel incorrectly validating the patient's name and address. Each of those agencies developed a process for reviewing that information which proved successful. Based on that information, FDNY EMS kept the division patient care report coordinator in the policy. They would compare each electronic copy of the ePCR against the scanned optical image, to ensure the information was correctly validated.

The utilization of the end-user focus groups in developing the policy had a positive response from the field personnel. The successful transition from the paper based patient care report to the scannable ePCR, is predicated on addressing both the adaptive and technical challenges (Heifetz and Linsky, 2002). By involving the field personnel prior to the on-line implementation in the field, the procedural rules were better accepted and understood (Carter, 1994).

Numerous sections of the SOP regarding the paper based patient care report (FDNY EMS OGP 2000, 102-15) were still applicable to the new policy. However, due to the observations and discussions during the end-user focus groups, it was decided to create the new ePCR procedure with emphasis on the administrative aspects and to include the step by step instructions for each part as separate addendums.

Allowing the supervisors to utilize the technology available with the ePCR system in performing various report queries will ultimately result in enhanced service delivery to the community (Heckerson, 1998). The information provided by these reports will aid in the continuous quality improvement of patient care and report documentation. Feedback from the Office of Medical Affairs and EMS Operations will identify trends and indicate which query reports should be generated on an as needed basis.

The FDNY will ultimately benefit from the new ePCR system and the standard operating procedure will provide an organized roadmap for the personnel to follow in executing its use. Examining the results from other agencies and continuous feedback from the compliance and billing departments will foster the improvement in compliance and increased revenue.

Recommendations

The FDNY EMS has a responsibility to provide optimum patient care and service to its citizens and to foster its pre-hospital care providers in obtaining that goal. By instituting the new HealthEMS ePCR system, it has taken advantage of technology to provide a better system for patient care documentation, and timely access to patient care information. This information will provide a conduit for continuous quality improvement.

In order to maximize the benefits of the new ePCR system, I recommend the following:

- Continuous communication between the field personnel and the compliance and billing departments to identify problem areas as they relate to compliance and billing practices.
- Changes to the procedure and training need to be made as necessary, based on the feedback

results of the query reports generated by the field supervisors, the Office of Medical Affairs EMS Operations, and the information obtained from the compliance and billing departments. The benefits expected from these changes should provide maximum revenue generation for the department and improve the quality of patient care and report documentation.

- Evaluative research needs to be conducted to track trends in patient care and monitor for compliance improvement and increased revenue generation with the inception of the new ePCR system.
- Monthly continuing medical education sessions should be developed based on trends identified during query reports to increase the quality of patient care and report documentation.
- An on-line survey should be developed and placed on the FDNY intranet system. This can track the organizational sentiment regarding procedural changes and provide a conduit for suggestions in improving the ePCR system.

In conclusion, I recommend that others who wish to conduct research into developing a policy include field personnel in the creation. It is beneficial to get a perspective from the end-users, since often times the policy makers are at a higher level, and not necessarily in touch with the needs of the people who will be utilizing the system or product.

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Appendix A

Observation Data Collection Form: ePCR

Location: FDNY Headquarters 9 Metrotech Center Brooklyn, NY

Date:

ePCR Form Completion

Scanalyzer Operation

Downloading EKG Data into Scanalyzer

ALS Coordinator Query Reports

Supervisor Query Reports

Discussion Items Existing SOP

Appendix B

EMSC OGP 102-06
September 23, 2004

DRAFT

PREPARATION AND REVIEW OF ELECTRONIC PREHOSPITAL CARE REPORTS

1. PURPOSE

1.1 To set forth policy and procedures for the preparation and review of the Electronic Prehospital Care Report (ePCR) in order to ensure that all patient care has been documented, in accordance with Federal, State and FDNY requirements.

2. SCOPE

2.1 This procedure applies to all members of the EMS Command.

3. ELECTRONIC PREHOSPITAL CARE REPORT (ePCR)

3.1 ePCR Description - The ePCR is a three-part scannable, carbonless form. The three components of the ePCR are as follows:

3.1.1 **Ambulance Copy**, pages 1 & 2, (white original)

3.1.2 **Hospital Copy**, pages 1 & 2, (carbonless copy)

3.1.3 **Notice of Privacy Practices and Patient Information Release/Assignment of Claim Sheet** (green copy)

3.2 The FDNY ePCR will be used exclusively by EMS Command units.

4. POLICY

4.1 This policy is to be used in conjunction with "Completing Electronic Prehospital Care Reports" Training Manual for specific instructions in the proper way to fill out the ePCR form.

4.2 An ePCR shall be completed whenever patient contact has been made. An ePCR is not required in situations where patient contact has **not** been established or in cases of 10-95A as approved by an **on-scene** Office of Medical Affairs (OMA) physician. On assignments where an ePCR is not required, appropriate documentation shall be made on the Unit Activity Log.

4.3 In order to ensure accurate name, address and insurance information is recorded in the patient and payer info sections, members should attempt to obtain personal identification (drivers license, government issued ID, etc.) and insurance identification information from the patient or family member and document appropriately.

4.4 All data concerning call dispatch, patient assessment, treatment, billing information and call disposition shall be documented as completely as possible. All appropriate areas must be completed and all information regarding that patient not sufficiently detailed elsewhere on the form, must be appropriately documented in the "Narrative History & Comments" section of the ePCR.

5. OPERATIONAL PROCEDURE

5.1 At the start of each tour, all crewmembers shall ensure they have an adequate number of ePCRs, properly stored in their vehicle document holder.

5.2 When making patient contact where an ePCR is required, crewmembers shall use legible, neat, complete and accurate documentation in completing each section of the ePCR. This is essential for each of the ePCR functions.

5.2.1 The double-sided clipboard provided as part of the assigned vehicle equipment, **must always be used** as a rigid writing surface when completing the ePCR.

5.2.2 Do not write anything in the form identification number or barcode area of the ePCR form.

5.2.3 Do not ***fold or staple*** the ePCR in any area.

5.2.4 In order to ensure that the ePCR forms are not creased or damaged, they should be stored in the vehicle document holder before and after being completed.

5.2.5 While both crewmembers are responsible for the completion of the ePCR, the Technician has the **primary** responsibility for the accuracy of the information.

A. All actual times are to be documented on the ePCR in military time.

B. Elapsed time is recorded as a whole number, reflecting the amount of minutes passed from on scene time (10-84).

C. When filling in the red data field boxes, use only capital letters and numbers. Do not use apostrophes, dashes, periods or slashes in these areas. Spaces are acceptable in place of these symbols.

5.3 When assessing and/or transporting any patient which requires an ePCR, including patients that refuse medical attention, the patient must always be given the green copy of the ePCR. A brief explanation of FDNY's privacy practices, patient information release and assignment of claim should be provided to the patient, and a signature from the patient or the patient's authorized representative or guardian shall be obtained in the "Information Release/Patient Authorized Representative Signature" section in box (1) on page 2 of the ePCR.

5.3.1 If the patient refuses to sign, darken the "patient refused to sign" box and leave the signature box (1) blank.

5.3.2 If the patient is unable to sign due to his or her physical and/or mental status/condition, status as a minor, or emergency needs, darken the "patient unable to sign" box and have one of the following sign in the "Information

Release/Patient Authorized Representative Signature" section in box (1) on page 2 of the ePCR:

A. A guardian, representative, adult relative or other adult designee arranging treatment or exercising responsibility for the patient's affairs.

B. If any of these patient representatives are not available, or unwilling to sign, the technician will then sign their own name in the "Information Release/Patient Authorized Representative" signature box (1), to verify that the patient is unable to sign.

NOTE: *Ensure that the patient's condition or circumstances indicating the reason for being unable to sign is properly documented on the ePCR.*

5.4 If a patient requests to be transported to a hospital that is outside of the Ten-Minute Rule or insists on being transported to a hospital that is on diversion.

5.4.1 Review the Out of Area Transport information with the patient and enter the name and number of the requested hospital in the appropriate box.

5.4.2 Have the patient sign his or her own name inside box (2) *"Out of Area Transport Patient Signature"*. If the patient refuses to sign, darken the appropriate box and leave the signature box (2) blank.

5.4.3 If the patient is unable to sign due to his or her physical and/or mental status/condition, status as a minor, or emergency needs, one of the following may sign in their place: a guardian, representative, adult relative or other adult designee arranging treatment or exercising responsibility for the patient's affairs. If any of these patient representatives are not available, or unwilling to sign, darken the "patient unable to sign" box and leave the "out of area transport" signature box (2) blank.

5.5 If the patient is competent and refuses medical care and/or transport to the hospital, follow the RMA procedure, darken the appropriate box in that section and have the patient sign the 'RMA Patient Signature' box (3), and have a witness sign in the designated box, when applicable.

NOTE: *If the patient is transported to the hospital but has refused a specific prehospital treatment or procedure (e.g., oxygen, immobilization), have the patient sign his or her own name in box (3) RMA Patient Signature and darken the box indicating that the patient refused specific prehospital care and enter that procedure in the space provided.*

5.6 The signature of the hospital-receiving agent, taking responsibility for the patient at the hospital, must be obtained prior to the Unit leaving the Emergency Department (ED). **Only the unit that physically transports the patient to the hospital is to obtain this signature.** (If your unit assisted in the transport but did not physically transport the patient in your vehicle, mark the appropriate box in the "patient not transported by" section. If you have a box marked in this section, **DO NOT** obtain a hospital receiving agent signature). The carbonless copies of both page 1 and 2 are submitted to the hospital to be included in the patient's hospital record.

NOTE: *The Hospital Receiving Agent's signature only documents the name of the person the patient was turned over to in the Emergency Department (ED). The signature is not an indication of the quality of care or documentation.*

6. ADMINISTRATIVE PROCEDURE

6.1 At the end of the tour, both pages of the original ePCRs completed during the tour, shall be brought to the unit's home battalion, for scanning and analyzing at the Battalion ePCR computer station.

6.2 The crewmember who completed the documentation on the ePCR shall sign in "Technician – signature" box prior to scanning the ePCR. *This signature verifies that all information on the ePCR is correct, and should be the signature of the crewmember who will be analyzing and validating the information.*

6.3 The crew will log on to the Battalion ePCR computer, scan, and upload each of their completed ePCRs.

6.4 Whenever the LP12 is used during patient care, the paramedics will download the EKG and call information from that tour, into the Battalion ePCR computer **prior** to scanning the ePCR.

6.5 After the original ePCR has been scanned and uploaded, the crew is to make any necessary corrections to validate the data that is displayed on the computer screen by the Analyzer program.

6.6 If an ePCR needs to be rescanned for any reason, the previous scanned copy of the same ePCR must be deleted first.

6.7 After all of the crew's ePCR forms have been analyzed and validated, the crew will place their original ePCR paper forms inside their ambulance checklist envelope. They will place the envelope and forms, along with the Unit Activity Log, in the ePCR security box at the battalion.

6.8 The crew will re-validate ePCR data when applicable, based on EMS officer/designee reports generated.

7. SUPERVISORY PROCEDURE

7. 7.1 Battalion Officers shall:

7.1.1 Log on to the system at the Battalion Officer's terminal each tour and review the data dashboard report for that battalion. This report will identify any data errors that were missed during the analyze phase, including:

A. All CAD numbers with patient contact dispositions missing a validated ePCR in the system.

B. All pertinent ePCRs that do not have an associated EKG in the system.

C. All ePCRs with code 55 (other) listed as the primary medical presenting problem or code 45 (unknown) listed as the cause of injury or illness.

D. Any other data as designated by EMS Command, OMA and/or the FDNY Compliance Officer.

E. Perform end run reports as directed by EMS Command and/or OMA.

7.1.2 If the data dashboard reflects an unmatched CAD number and ePCR data, the officer will manually match the CAD number with the appropriate ePCR. If the ePCR data is missing because it was never scanned and uploaded into the system, check the respective crew's envelope for the hard copy. If the ePCR is located, scan and upload the ePCR into the Battalion ePCR computer. Once the ePCR is uploaded, analyze and validate, if possible. If the officer is unable to validate the ePCR, ensure that the respective crew analyzes and validates the ePCR at the start of their next tour of duty.

7.1.3 If the data dashboard reflects unattached EKG and ePCR data, the officer will manually match the EKG with the existing ePCR. If the EKG data is missing, ensure the respective crew downloads their EKG data into the battalion ePCR computer and matches it to the appropriate ePCR data in the system.

7.1.4 If the data dashboard reflects an ePCR with code 55 listed as the primary medical presenting problem or code 45 listed as the cause of injury or illness, the officer will review the electronic scanned image of the associated ePCR in its entirety. If information is found in the narrative or other sections of the ePCR that indicate a more descriptive code, the officer should change the code 55 and or code 45 to the appropriate code. The code system descriptions should then be reviewed with the crew.

7.1.5 If the officer reviews or makes any changes on a validated ePCR, the officer should make an entry in the comments section of the data field, indicating what items on the ePCR needed to be changed and what it was changed to.

7.1.6 If the officer conducts a QA/QI session with the crew regarding documentation on a specific ePCR, that information should be included in the comments section.

7.1.7 Perform the analyzer clean up task each tour and clean the scanner on a daily basis.

7.1.8 The officer should serve as a resource to the EMTs and Paramedics in the appropriate method for filling out, scanning and validating ePCRs as outlined in the training manual.

7.1.9 Following verification that all CAD numbers with patient contact dispositions have matching validated ePCRs, ensure that all ambulance checklist envelopes from the previous day's tour are reviewed and filed. Place all ePCRs that were inside the envelope, into the station security bin for pickup by the Division Supply Coordinator for transport to the collection center.

7.1.10 Review, endorse and file Unit Activity Logs.

7.1.11 Secure ePCRs in the battalion for 72 hours after they have been scanned, uploaded and analyzed. All supervisor reviews and necessary correcctions should be completed on these ePCRs during this time frame. At the end of this period, the ePCRs should be bundled for Division pickup.

7.2 The Battalion Commanding Officer, or designee, shall:

7.2.1 Ensure that Battalion Officers review the ePCR data dashboard during their tour and perform the necessary data functions to address problems identified.

7.2.2 Ensure that Battalion Officers are serving as a resource to the EMTs and Paramedics in the appropriate method for filling out, scanning and validating ePCRs as outlined in the electronic PCR training manual.

7.2.3 Assist the Battalion Officers in developing remedial education methods for ePCR compliance.

7.2.4 Log on to the Battalion ePCR system and review the Battalion data dashboard at random to identify patterns or trends in data and share that information with battalion officers for follow up. Indicate in the comments section of the ePCR data field, any review or QA/QI conducted.

7.2.5 Perform end run reports as directed by EMS Command and/or OMA.

7.2.6 Ensure all ePCRs for the past 72 hours have completed supervisor review and are prepared for Division pickup.

7.3 The EMS Division Commanders, or designee, shall:

7.3.1 Review compliance reports and identify the areas requiring remedial education.

7.3.2 Share the compliance report information with the Battalion Commanding Officers, and assist in developing a remedial education plan to achieve ePCR compliance.

7.3.3 Log on to the Division ePCR system and review the data dashboard for all battalions within the division, at random to identify patterns or trends in data and share that information with the Battalion Commanding Officers for follow up.

7.3.4 Perform end run reports as directed by EMS Command and/or OMA.

7.4 Division ALS Coordinators, shall:

7.4.1 Log on to the Division ePCR system and review the ALS call details displayed on the data dashboard on a daily basis, for all Battalions within their Division.

7.4.2 Notify their respective Medical Affairs physician of any patterns or trends in data to be addressed in future CME sessions.

7.4.3 Perform end run reports as directed by EMS Command and/or OMA.

7.5 Division Patient Care Report Coordinators, shall:

7.5.1 Log on to the Division ePCR system and review the ePCR data table for all ePCRs generated the previous day. Compare the optical image of each ePCR against the patient name and billing address data listed in the table.

7.5.2 Correct the billing data as necessary in the data field and indicate those changes in the data field comments section.

7.6 Division Supply Coordinators, shall:

7.6.1 Collect the ePCRs in the security bin from each of their respective battalions on a daily basis, and deliver to the Division Office.

7.6.2 Collect the ePCRs in the security bin from the Division Office as instructed by EMS Operations, and deliver them to the ACR collection point.

7.7 EMS Operations, shall:

7.7.1 Evaluate feedback reports from the compliance and billing units to identify trends in data requiring remedial education, and disseminate that information to the respective division commanders.

7.7.2 Update the Preparation and Review of ePCR policy as necessary.

8. ADDENDUMS

8.1 Addendum A: FDNY Electronic Prehospital Care Report

8.2 Addendum B: Completing Electronic Prehospital Care Reports (ePCRs)

8.3 Addendum C: LifePak 12 and ePCR Instructions

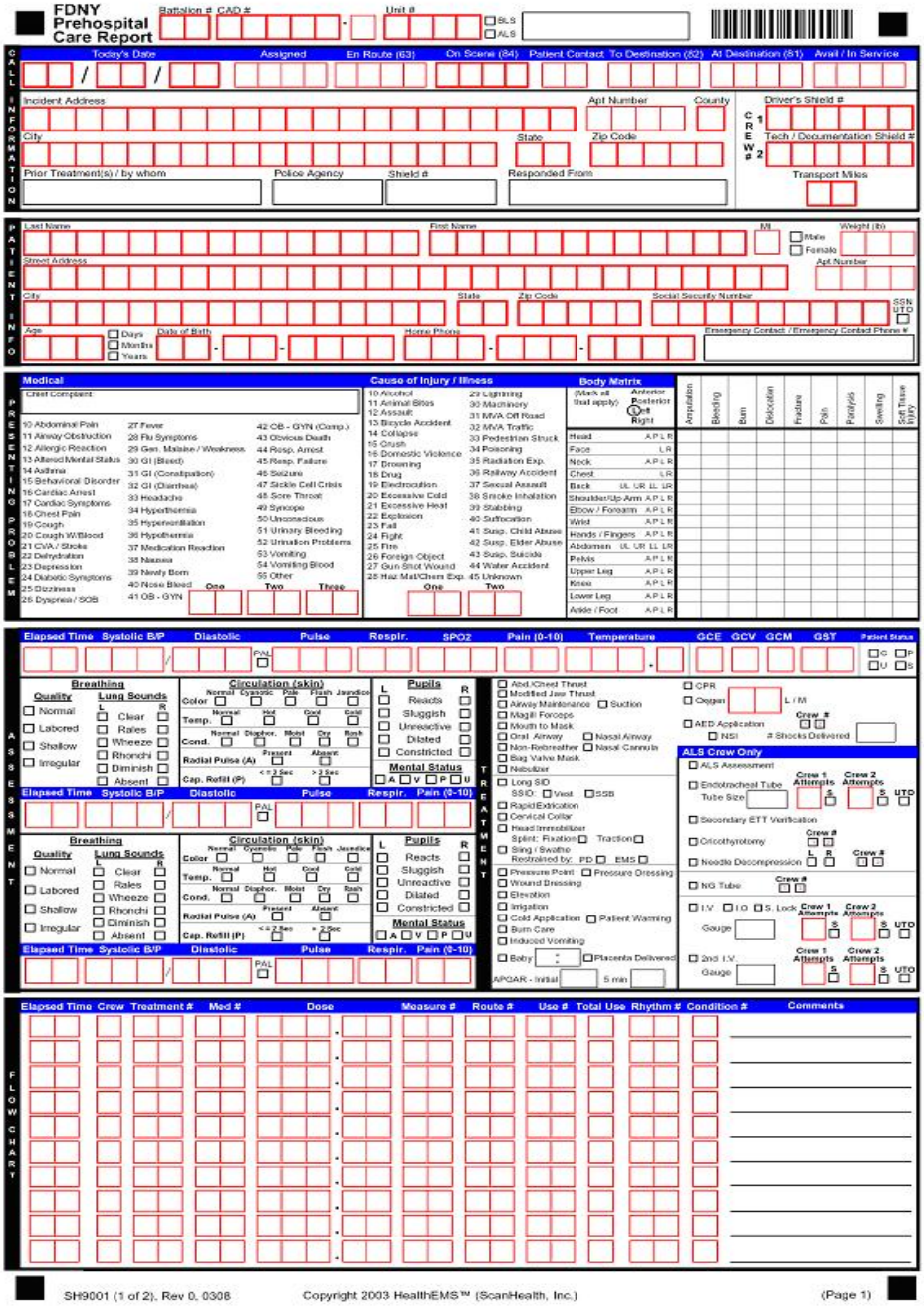
8.4 Addendum D: Transferring Data Form the LifePak 12

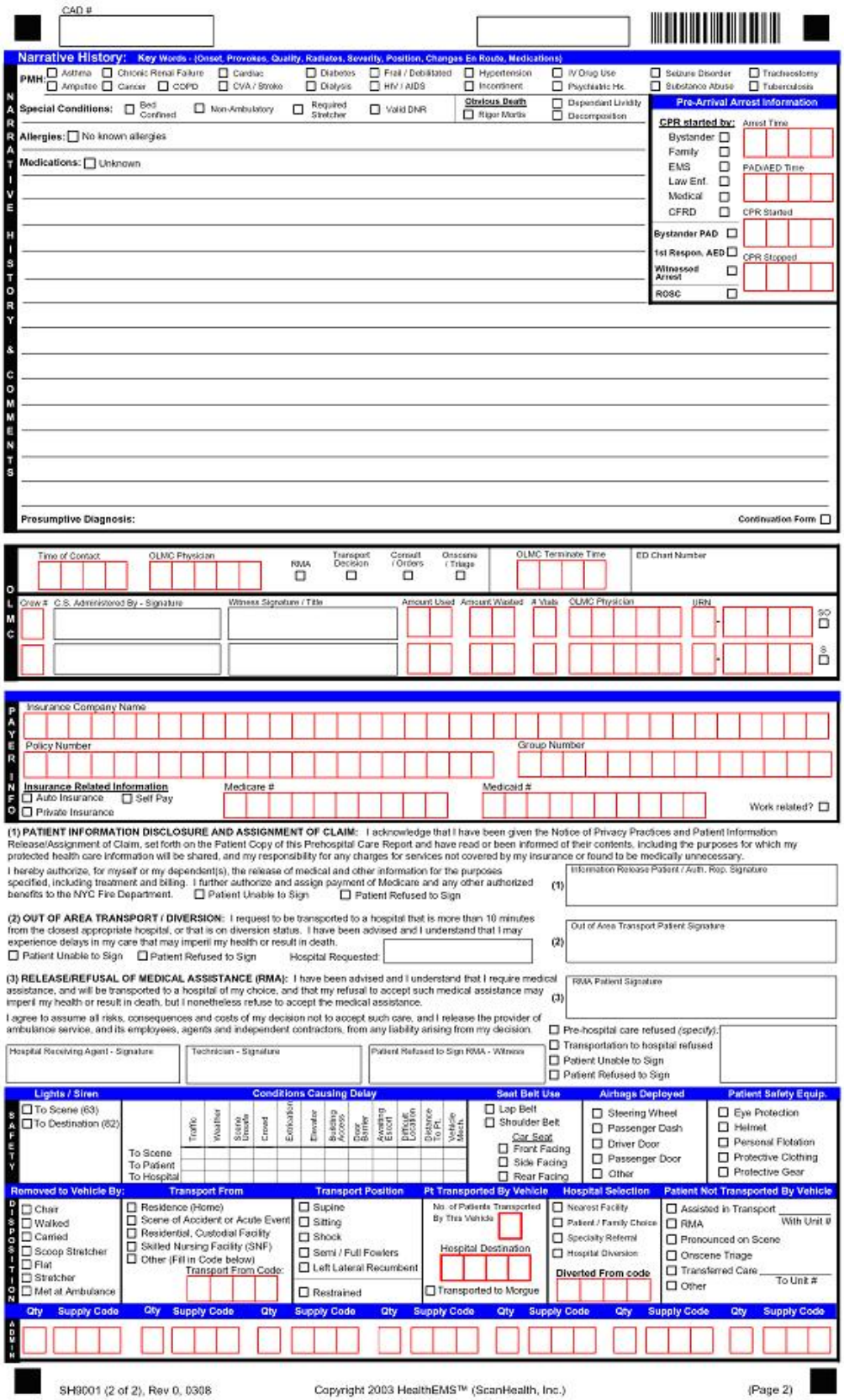
BY ORDER OF THE FIRE COMMISSIONER AND THE CHIEF OF DEPARTMENT

DRAFT

EMSC OGP 102-06, ADDENDUM A
July xx, 2004

FDNY ELECTRONIC PREHOSPITAL CALL REPORT (ePCR)





CAD #

Narrative History: Key Words - (Onset, Provokes, Quality, Radiates, Severity, Position, Changes En Route, Medications)

NARRATIVE HISTORY & COMMENTS

PMH: ☐ Asthma ☐ Chronic Renal Failure ☐ Cardiac ☐ Diabetes ☐ Frail / Debilitated ☐ Hypertension ☐ IV Drug Use ☐ Seizure Disorder ☐ Tracheostomy ☐ Amputee ☐ Cancer ☐ COPD ☐ CVA / Stroke ☐ Dialysis ☐ HIV / AIDS ☐ Incontinent ☐ Psychiatric Hx. ☐ Substance Abuse ☐ Tuberculosis

Special Conditions: ☐ Bed Confined ☐ Non-Ambulatory ☐ Required Stretcher ☐ Valid DNR

Obvious Death: ☐ Rigor Mortis ☐ Dependant Lividity ☐ Decomposition

Allergies: ☐ No known allergies

Medications: ☐ Unknown

Pre-Arrival Arrest Information

CPR started by: ☐ Bystander ☐ Family ☐ EMS ☐ Law Enf. ☐ Medical ☐ CFRD

Arrest Time

PAD/AED Time

CPR Started

CPR Stopped

☐ Bystander PAD ☐ 1st Respon. AED ☐ Witnessed Arrest ☐ ROSC

Presumptive Diagnosis:

Continuation Form ☐

OLMC

Time of Contact | OLMC Physician | RMA ☐ | Transport Decision ☐ | Consult / Orders ☐ | Onscene / Triage ☐ | OLMC Terminate Time | ED Chart Number

Crew # | C.S. Administered By - Signature | Witness Signature / Title | Amount Used | Amount Wasted | # Vials | OLMC Physician | URN | SO ☐ | S ☐

PAYER INFO

Insurance Company Name

Policy Number

Group Number

Insurance Related Information: ☐ Auto Insurance ☐ Self Pay ☐ Private Insurance

Medicare #

Medicaid #

Work related? ☐

(1) PATIENT INFORMATION DISCLOSURE AND ASSIGNMENT OF CLAIM: I acknowledge that I have been given the Notice of Privacy Practices and Patient Information Release/Assignment of Claim, set forth on the Patient Copy of this Prehospital Care Report and have read or been informed of their contents, including the purposes for which my protected health care information will be shared, and my responsibility for any charges for services not covered by my insurance or found to be medically unnecessary.

I hereby authorize, for myself or my dependent(s), the release of medical and other information for the purposes specified, including treatment and billing. I further authorize and assign payment of Medicare and any other authorized benefits to the NYC Fire Department. ☐ Patient Unable to Sign ☐ Patient Refused to Sign

(1) Information Release Patient / Auth. Rep. Signature

(2) OUT OF AREA TRANSPORT / DIVERSION: I request to be transported to a hospital that is more than 10 minutes from the closest appropriate hospital, or that is on diversion status. I have been advised and I understand that I may experience delays in my care that may imperil my health or result in death.

☐ Patient Unable to Sign ☐ Patient Refused to Sign Hospital Requested:

(2) Out of Area Transport Patient Signature

(3) RELEASE/REFUSAL OF MEDICAL ASSISTANCE (RMA): I have been advised and I understand that I require medical assistance, and will be transported to a hospital of my choice, and that my refusal to accept such medical assistance may imperil my health or result in death, but I nonetheless refuse to accept the medical assistance.

I agree to assume all risks, consequences and costs of my decision not to accept such care, and I release the provider of ambulance service, and its employees, agents and independent contractors, from any liability arising from my decision.

(3) RMA Patient Signature

☐ Pre-hospital care refused (specify): ☐ Transportation to hospital refused ☐ Patient Unable to Sign ☐ Patient Refused to Sign

Hospital Receiving Agent - Signature | Technician - Signature | Patient Refused to Sign RMA - Witness

SAFETY

Lights / Siren: ☐ To Scene (63) ☐ To Destination (82)

Conditions Causing Delay: Traffic, Weather, Scene Unsafe, Crowd, Extrication, Elevator, Building Access, Door Barrier, Awaiting Escort, Difficult Location, Distance To Pt., Vehicle Mech. — To Scene / To Patient / To Hospital

Seat Belt Use: ☐ Lap Belt ☐ Shoulder Belt — Car Seat: ☐ Front Facing ☐ Side Facing ☐ Rear Facing

Airbags Deployed: ☐ Steering Wheel ☐ Passenger Dash ☐ Driver Door ☐ Passenger Door ☐ Other

Patient Safety Equip.: ☐ Eye Protection ☐ Helmet ☐ Personal Flotation ☐ Protective Clothing ☐ Protective Gear

DISPOSITION

Removed to Vehicle By: ☐ Chair ☐ Walked ☐ Carried ☐ Scoop Stretcher ☐ Flat ☐ Stretcher ☐ Met at Ambulance

Transport From: ☐ Residence (Home) ☐ Scene of Accident or Acute Event ☐ Residential, Custodial Facility ☐ Skilled Nursing Facility (SNF) ☐ Other (Fill in Code below) — Transport From Code:

Transport Position: ☐ Supine ☐ Sitting ☐ Shock ☐ Semi / Full Fowlers ☐ Left Lateral Recumbent ☐ Restrained

Pt Transported By Vehicle: No. of Patients Transported By This Vehicle — Hospital Destination — ☐ Transported to Morgue

Hospital Selection: ☐ Nearest Facility ☐ Patient / Family Choice ☐ Specialty Referral ☐ Hospital Diversion — Diverted From code

Patient Not Transported By Vehicle: ☐ Assisted in Transport ☐ RMA ☐ Pronounced on Scene ☐ Onscene Triage ☐ Transferred Care ☐ Other — With Unit # — To Unit #

ADMIN

Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code

SH9001 (2 of 2), Rev 0, 0308

(Page 2)

DRAFT

EMSC OGP 102-06, ADDENDUM B
JULY XX, 2004

COMPLETING THE ELECTRONIC PREHOSPITAL CARE REPORT (ePCR)

1. PURPOSE

1.1 To set forth the detailed guidelines for the preparation of the new Electronic Prehospital Care Report (ePCR) to ensure that all patient care is documented in accordance with Federal, State and FDNY requirements.

2. SCOPE

2.1 This procedure applies to all members of the FDNY EMS Command who provide prehospital emergency medical treatment and transport in the New York City 911 Emergency Medical Service system.

3. DEFINITIONS

3.1 **Cause of Illness / Injury (COI)** – A list of causes of an injury or illness but not a traditional mechanism of injury list. (E.g., smoke inhalation would be the Cause and the Presenting Problem is SOB or Resp. Arrest).

3.2 **Elapsed Time** – The estimated number of elapsed minutes from the time the Unit arrives on scene (84) to the time of patient contact, treatment performed and/or medication given.

3.3 **Patient Contact Time** – The estimated number of elapsed minutes from the time the Unit arrives on scene (84) to the time of the actual physical patient contact.

3.4 **Flowchart –** A chronological listing of treatments performed and medications given to a patient.

4. POLICY

4.1 An ePCR shall be completed whenever patient contact has been made. An ePCR is not required in situations where patient contact has **not** been established.

4.2 All data concerning call dispatch, patient assessment, treatment, billing information and call disposition must be documented as completely as possible. All appropriate areas must be completed and all information regarding the patient not sufficiently detailed elsewhere on the form must be appropriately documented in the 'Narrative History & Comments' section of the ePCR.

4.3 The ePCR seems complex and appears to require a great deal of information be obtained from the patient. However, once the form is mastered, it facilitates the recording of the necessary information quickly, accurately and completely and with less writing than the current ACR.

5. ELECTRONIC PREHOSPITAL CARE REPORT (ePCR)

5.1 The ePCR form will be used exclusively by EMS Command units.

5.2 **ePCR Description** - The ePCR is a three-part carbonless form. The ePCR **must** be used at all times with the double-sided clipboard provided. The three components of the ePCR are as follows:

5.2.1 **Ambulance Copy**, pages 1 & 2, (white original) – Both pages of the original ePCR shall be brought back to the Battalion at the end of the tour, scanned and analyzed. Following the scanning and analysis, ePCRs shall be submitted to the Battalion Officer.

5.2.2 **Hospital Copy**, pages 1 & 2, (carbonless copy) – If the patient is transported, the carbonless copy of both page 1 and 2 are submitted to the hospital to be included in the patient's hospital record.

A. Hospital Copy, Page 1 - on the back of this sheet are the Pain Scale, APGAR Scoring System, Adult and Infant Glasgow Coma Scale, Adult and Infant Trauma Score and the codes for completing the flowchart on the bottom of the front of page 1 of the Ambulance Copy.

B. Hospital Copy, Page 2 - on the back of this sheet is the Spanish translation of the Patient Information Disclosure and Assignment of Claim, the Out of Area Transport/Diversion and the Release/Refusal of Medical Assistance (RMA) statements.

NOTE: *These translations on the back of the Hospital Copy page 2 are provided for immediate patient reference. The patient is to sign the form where indicated on Ambulance Copy, Page 2.*

5.2.3 **Patient Information Sheet** (green copy) – This page details specific information for the patient. It must **always** be given to the patient. It provides an explanation of FDNY's Privacy Practices, Patient Information Release and Assignment of Claim, Refusal of Medical Assistance, Out of Area Transport/Diversion, On-Scene Triage Notice and Health Insurance Information.

A. The form is printed in both English and Spanish to inform each patient of specific information related to financial liabilities for ambulance or other services furnished to the patient for the express purpose of processing a claim.

NOTE: *Although this page is given to the patient, members shall still obtain the patient's signature where appropriate on Ambulance Copy, Page 2.*

6. GLOBAL INSTRUCTIONS

6.1 Neat, complete, legible and accurate documentation is essential for each of the ePCR functions. All information in each section of the ePCR shall be filled out as accurately, legibly and completely as possible.

6.2 Use blue or black ball point pen and apply pressure as you write. Print clearly and ***keep all information within each box***. Darken in boxes completely.

6.3 The white, double-sided clipboard provides a rigid writing surface and **must always be used** when completing the ePCR.

6.4 While both crewmembers are responsible for the completion of the ePCR, the Technician has the **primary** responsible for the accuracy of the information.

6.5 All times documented on the ePCR are written in military time except for Patient Contact and when Elapsed Time is used in the Assessment and Flowchart sections.

6.6 Members shall not use apostrophes, dashes, periods or slashes when documenting information on the ePCR. Only capital letters and numbers shall be used. Spaces are acceptable.

6.7 Members shall **not write UTO** when documenting information on the ePCR. Whenever a Crew is unable to obtain information from a patient, leave the specific section blank unless otherwise directed.

7. PROCEDURE

7.1 **Completing Page One of the ePCR** - The crewmember completing the ePCR shall complete all information in each section as accurately, legibly and completely as possible.

7.1.1 Incident Information and Form Identification

A. **Battalion #** – Document the two digit Battalion number that the Unit is assigned, but not necessarily where the Crew is assigned.

B. **CAD #** – Document the number assigned by Dispatch Operations. For multiple patients, use the CAD extension with a sequential alpha character in the box provided between the CAD # and Unit # (e.g., ‘0437 A’ or ‘0437 B’).

C. **Unit # -** Document the ambulance unit designation including tour (e.g., 44C3, 07Y2).

D. **Unit Type** – Darken in the appropriate box to indicate the type of unit, regardless of the level of care provided (e.g., 44C3 shall darken BLS, 07Y2 shall darken ALS).

E. **Form Identification Number and Barcode** – This is a pre-printed/pre-assigned number. Members shall not write or staple in this area of the form.

7.1.2 **Call Information**

A. **Today's Date** – Document the date using the Month/Day/Year format. Six digits shall be used: two for the month (MM), two for the day (DD), and two for the year (YY). Months and dates with only one digit shall have zeros placed before the digit (e.g., July 1, 2004 shall read "070104").

B. **Assigned** – Document the time the initial call was received from the Emergency Medical Dispatcher.

C. **En Route (63)** – Document the time from CAD that the Unit is enroute to the scene.

D. **On Scene (84)** – Document the time the Unit arrived at the scene.

E. **Patient Contact** – Document the estimated number of minutes of *elapsed* time from the time the Unit arrived on scene (84) to time of actual physical patient contact.

F. **To Destination (82)** – Document the time the Unit is enroute to the Hospital Destination.

G. **At Destination (81) –** Document the time the Unit arrived at the Hospital Destination.

H. **Avail / In Service** – Document the time the Unit has completed the assignment and is available to respond to another assignment or is going off service.

NOTE: *Document the appropriate call times in the boxes provided for each item. Note that four digits are used and all times - except Patient Contact and Elapsed Time - are written in military time (e.g., 12:30 a.m. is written 0030 and 12:30 p.m. is written 1230).*

I. **Incident Address and Apartment Number** – Document the street address where the incident occurred, including the apartment number, where applicable.

NOTE: *Units shall not use apostrophes, dashes, periods or slashes when documenting the incident address. Only letters and numbers should be used. Using spaces and the acceptable locations abbreviations listed on the reference sheet are acceptable (e.g., 13-406 Queens Boulevard shall be written 13 406 QUEENS BLVD).*

J. **County** – Document the county where the incident occurred. County codes are listed on the reference sheet.

K. **City/State/Zip Code** – Document this information in the boxes provided. If the zip code is unknown, leave this field blank. Do not document UTO.

L. **Prior Treatment(s)/by whom** – Document any treatment given to the patient, and the name of the agency or person(s) that rendered the care, prior to the arrival of the ambulance crew (e.g., O_2 given by CFRD Company Engine 255). If additional space is needed, it shall be included in the 'Narrative History & Comments' section. If the patient received no prior treatment, leave this area blank.

NOTE: *Specific information about a cardiac arrest prior to the unit's arrival shall be documented in the Pre-Arrival Arrest Information section on the top of page 2.*

M. **Police Agency, Shield #** – Document the police agency (e.g., NYPD, PAPD) and the shield number of the police personnel on scene prior to the Unit's arrival.

N. **Responded From** – Document the exact cross street location (CSL) from which the Unit responded. Code 10-89 or a hospital number is not acceptable documentation.

O. **Crew Numbers –** While both crewmembers are equally responsible for patient care and the completion of the PCR, the Technician has the primary responsibility for the accuracy of the information.

1. Driver's Shield # – Document the shield number of the driver (Crew # 1)

2. Tech/Documentation Shield # – Document the shield number for the technician who completed and signed the PCR (Crew # 2). If crewmembers change roles during a call, note the change on the Unit Activity Log (UAL).

P. **Transport Miles** – Document the number of miles traveled from the incident location to the Hospital Destination. The mileage shall be entered in whole numbers and rounded up to the next whole number (e.g., 0.3 miles shall be written as 1 mile, 4.3 miles shall be written as 5 miles).

7.1.3 **Patient Info -** In order to verify the patient's identity, home address and insurance, members ***must request*** a form of valid personal identification such as a driver's license, (NYS) Non-Driver Identification Card ***and*** medical insurance card. Members shall not delay or deny patient care or transport if the patient refuses or is unable to provide identification.

A. **Last Name/First Name/MI** – Document the patient's last name and first name in the designated boxes as appropriate. Only capital letters are acceptable using one space per letter. Omit apostrophes, dashes, periods or slashes (e.g., O'MALLEY shall be written as OMALLEY, COSTA-GAVRAS shall be written as COSTA GAVRAS).

1. If there is not enough space available for the entire name, fill in as many letters as possible.

2. If unable to obtain, a description of the patient's race preceded by 'Unknown' shall be written in these boxes (e.g., Unknown Hispanic). This area shall never be left blank and '*JANE/JOHN DOE*' shall **NOT** be used.

B. **Male/Female** – Darken the appropriate box to indicate the patient's gender.

C. **Weight** – Document the patient's estimated weight in pounds.

D. **Street Address/Apt. Number** – Document the patient's home address and apartment number in the boxes provided. Use the standard list of street type abbreviations printed on the reference sheet. If the patient is homeless write "HOMELESS".

E. **City/State/Zip Code** – Document the city, state and zip code where the patient resides. If the zip code is unknown, leave it blank. Do **not** document UTO.

F. **Social Security Number** – Document the patient's nine-digit social security number. If this number is unobtainable leave the spaces blank and darken the "SSN UTO" box.

G. **Age** – Document the patient's age and darken the appropriate box for Days, Months or Years. The age of a newborn as 1 Days.

H. **Date of Birth** – Document the patient's date of birth in two-digit month, two-digit day and four-digit year format. Months and dates with only one digit shall have zeros placed before the digit (e.g., March 8, 1956, shall read "03 08 1956.") If unobtainable, leave this section blank.

I. **Home Phone** – Document the patient's home phone number (area code first). If this information is unavailable or unobtainable, leave it blank.

J. **Emergency Contact / Emergency Contact Phone Number** – Document the name and phone number of a contact person for the patient. If unable to obtain, leave this area blank. Do **not** document UTO.

7.1.4 **Presenting Problem**

A. **Chief Complaint** – Document the reason why an ambulance was called using the patient's own words. If the patient is unresponsive write 'UNRESPONSIVE'.

B. **Medical Presenting Problem** – Circle all conditions that apply to the patient's condition. Prioritize up to three conditions circled by entering the number in the boxes labeled 'One', 'Two' and 'Three'. Box 'One' is the principal presenting problem. Additional patient conditions shall be documented in the 'Narrative History & Comments' section.

C. **Cause of Injury / Illness** – Circle all causes of the injury or illness that apply to the patient. Prioritize up to two causes circled by entering the numbers in the boxes labeled 'One' and 'Two'. Box 'One' is the primary cause.

NOTE: *This is not a traditional Mechanism of Injury (MOI) list, but a list of causes of an injury or illness (e.g., smoke inhalation would be the Cause and the Presenting Problem is SOB or Resp. Arrest).*

D. **Body Matrix** – This section is only to be completed to document a type of injury or trauma. **It is not to be used to document medical conditions.** Members shall darken all the injury areas that apply and circle the appropriate location of the injury using the left column of locations.

7.1.5 **Assessment** – Completely document the assessment provided to the patient.

A. Initial Assessment

1. **Elapsed Time** – Document the estimated number of *elapsed* minutes from the time the Unit arrived on scene (84) to the time of the initial assessment.

2. **Systolic Diastolic B/P** – Document the patient's Systolic and Diastolic blood pressure using only numeric characters. If the blood pressure was obtained by palpation, darken the PAL box.

3. **Pulse** – Document the number of beats per minute and indicate the quality, rhythm and characteristics in the 'Narrative History & Comments' section.

4. **Respir** – Document the number of respirations per minute.

5. **SPO2** (Pulse Oximetry) – Partial pressure of oxygen in the hemoglobin as measured using pulse oximetry value up to 100. ALS Units equipped with a pulse ox probe for the LP 12 shall document the patient's pulse ox value from the LP 12. All other Units shall leave this area blank.

6. **Pain** (0-10) – Using the pain scale printed on the back of page 1 of the Hospital copy, document the level of pain experienced by the patient in the appropriate boxes with '0' being no pain and '10' being the worst.

7. **Temperature** – Members shall leave this area blank.

8. **Glasgow Coma Scale Scores** – Document the individual GCS component scores using, the chart printed on the back of page 1 of the Hospital copy.

    a. Glasgow Coma Eyes (GCE) Score – Document the patient's score (1-4)

    b. Glasgow Coma Verbal (GCV) Score – Document the patient's score (1-5)

    c. Glasgow Coma Motor (GCM) Response Score – Document the patient's score (1-6)

    d. Glasgow Scale Total Score – The sum of the GCE, GCV and GCM fields. Document the patient's total score.

9. **Patient Status** – Darken the box that best represents the patient's status using the CUPS scale.

    a. CUPS Criteria:

Critical	• Patients either receiving CPR, in respiratory arrest or requiring and receiving life-sustaining ventilatoy/circulatory support.
Unstable	• Poor general impression • Unresponsive with no gag or cough reflexes • Responsive but unable to follow commands • Difficulty breathing
Potentially Unstable	• Pale skin or other signs of poor perfusion (shock) • Complicated childbirth • Uncontrolled bleeding • Severe pain in any area of the body • Severe chest pain, especially with a systolic BP of less than 100mmHg • Inability to move any part of the body
Stable	• Minor illness, minor isolated injury, uncomplicated extremity injuries, and/or any patient that cannot be categorized as Critical, Unstable or Potentially unstable.

10. **Breathing**

    a. **Quality** – Darken the box that best describes the patient's quality of breathing. Darken only one box

    b. **Lung Sounds** – Darken all appropriate boxes for both left and right lungs, based on the patient assessment. More than one box may be darkened for each lung.

11. **Circulation** (skin) – Darken the box that best describes the patient's skin color, temperature, condition, and radial pulse (adult) or capillary refill (pediatric).

12. **Pupils** – Darken all the boxes that best match the patient's pupil activity. More than one box may be darkened for each pupil.

13. **Mental Status** – Darken the most appropriate response.

B. **Second Vital Signs Assessment** – Darken each field as previously described.

C. **Third Vital Signs Assessment** – Darken each field as previously described when a third set of vital signs is taken.

7.1.6 **Treatment –** Completely document all treatments provided to the patient.

A. **Respiratory and Airway** – Darken all treatments performed.

B. **Immobilization** – Darken all treatments performed.

1. SID – Spinal Immobilization Device

2. SSID – Short Spinal Immobilization Device (e.g., short board, vest type)

3. SSB – Short Spine Board

C. **Wound Care** – Darken all treatments performed.

D. **Baby** – Document the time the baby was delivered. Darken the box if the placenta was delivered. In addition, members shall document the baby's initial APGAR score at the time of delivery and at five (5) minutes after the time of delivery.

E. **CPR** – Darken the box if the Unit provides CPR to the patient.

F. **Oxygen** – Darken the box and document the rate of O_2 delivered to a patient in liters per minute.

G. **AED Application** – This section is used only by BLS Unit when they apply their AED to the patient. Darken the appropriate box to indicate which BLS crewmember (# 1 or # 2) applied the AED.

1. No Shock Indicated (NSI) – darken this box only if no shock was indicated by the AED over the entire course of treatment of the patient.

2. When a shock is indicated, document the number of shocks delivered by the AED during the entire course of treatment of the patient.

NOTE: *ALS Units shall document patient defibrillation as a treatment in the Flowchart section at the bottom of page 1.*

H. **ALS Crew Only**

1. **ALS Assessment** – Darken the box whenever patient contact and an ALS assessment are made.

2. **Endotracheal Tube** – Document the size of the tube used and enter the number of attempts to insert the tube by each member. Darken the 'S' box if the tube was successfully inserted. Darken the UTO box if neither staff member was able to insert the tube.

3. **Secondary ETT Verification** – Darken this box if a device for secondary confirmation of endotracheal tube placement was used. Document the specific device used along with the indication of a successful result received in the Narrative section.

4. **Cricothyrotomy /Needle Decompression /NG Tube** – Darken the appropriate boxes for each treatment performed and indicate which crewmember (#1 or #2) performed the treatment.

5. **IV /IO /S. Lock or 2nd IV** – Document the size of the gauge of catheter used. Enter the number of IV attempts for each crewmember and darken the 'S' box if IV access was successfully secured. Darken the UTO box if neither staff was able to secure IV access.

7.1.7 **Flowchart** – A chronological listing of treatments performed and medications given to a patient. Reference codes for this section including Treatment, Medication, Measure, Route, Use, Cardiac Rhythm and Condition are listed on the back of page 1 of the Hospital copy.

NOTE: *BLS medication administrations including aspirin, albuterol and glucose are documented in this section.*

A. **Elapsed Time** – Document the estimated number of minutes of *elapsed* time from the time the Unit arrived On Scene (84) to the time the treatment was performed and/or medication given.

B. **Crew** – Document the number of the crewmember (#1 or #2) that performed the treatment or administered the medication.

C. **Treatment #** – Document the code number for the treatment performed on the patient using the corresponding code on the back of page 1.

D. **Medication #** – Document the code number for the medication administered to the patient using the corresponding code on the back of page 1.

E. **Dose** – Document the dosage or volume of the specific medication or treatment. Fractions are indicated in hundredths in the boxes to the right of the decimal.

F. **Measure #** – Document the code for the unit of measure of the treatment performed or medication administered using the corresponding code from the back of page 1.

G. **Route #** – Document the code that describes the route through which the medication was administered using the corresponding code on the back of page 1.

H. **Use #** – This is used to indicate multiple uses of the same treatment or medication over a period of time. Document the corresponding 'Use code' from the back of page 1.

I. **Total Use** – This field is only used if a value is entered in the 'Use #' field. Document the number of times that the treatment or medication administration was repeated.

J. **Rhythm #** – Document the patient's cardiac rhythm using the corresponding Rhythm code from the back of page 1.

1. **Condition #** – Indicate the effect the medication or treatment had on the patient's condition using the corresponding code from the back of page 1 (e.g., 0 = No Change, 1 = Improved/Positive Impact, 2 = Worsened/Negative Impact).

K. **Comments** – Document in shorthand (e.g., 1 epi, Q3, VFIB or 1 Albuterol via NEB) any pertinent information associated with medications and treatments.

7.2 COMPLETING PAGE 2 OF THE ePCR

7.2.1 **CAD # -** Document the CAD number from the front of the ePCR in case the pages become separated.

7.2.2 **Form Identification Number and Barcode** – A pre-printed/pre-assigned number. Members shall not write or staple in this area of the form.

7.2.3 **Narrative History & Comments Section** – Document the patient's medical history, the member's presumptive diagnosis and other pertinent patient information not indicated in other areas of the form. If a patient's condition changes during a call, or as a response to a specific treatment, document a detailed explanation in this section.

A. **PMH** – Darken all appropriate boxes that apply to the patient's past medical history.

B. **Special Conditions** – Document any special conditions related to the patient that may affect treatment and/or transport.

C. **Obvious Death** – This is used to support documenting Medical Presenting Problem number '43 - Obvious Death' on page one of the ePCR. Darken the all conditions that support the decision to use 'Obvious Death' as the medical presenting problem.

D. **Allergies** – Darken the box if the patient has no known allergies. Otherwise, list the patient's allergies in the space provided.

E. **Medications** – List the names and prescribed dosages of the patient's current medications using as much space and necessary. Darken the box if it is unknown if the patient is taking any prescribed medications.

F. **Presumptive Diagnosis** – Document your clinical impression of the patient's condition that led to the management of the patient.

G. **Continuation Form** – Members shall leave this area blank.

7.2.4 **Pre-Arrival Arrest Information** – Document ***only*** cardiac arrest care provided by others that took place **prior** to the unit's arrival. If this section on the ePCR is completed, there should be some information entered in the '*Prior Treatment(s) / by whom*' box on page 1.

A. **CPR Started By -** Darken the appropriate box indicating who provided the CPR performed **before** the unit's arrival. "EMS" includes all emergency personnel, including other ambulance units.

B. **Bystander PAD** – Darken the box if anyone other than the crew defibrillated the patient using a Public Access Defibrillator.

C. **1st Respon. AED** – Darken the box if a first responder defibrillated the patient (e.g., CFRD, PD, other EMS).

D. **Witnessed Arrest** – Darken this box if anyone other than the members actually witnessed the arrest.

E. **ROSC** – Darken the box if the members were told that the patient achieved a return of spontaneous circulation prior to the arrival of the ambulance crew.

F. **Arrest Time** – Document the estimated time the arrest occurred.

G. **PAD/AED Time** – Document the estimated time that the patient was defibrillated by a bystander or first responder.

H. **CPR Started** – Document the estimated time that CPR was originally started prior to the arrival of the unit.

I. **CPR Stopped** – Document the estimated time that CPR was stopped prior to the arrival of the unit.

NOTE: *Members shall use the 'Narrative History & Comments' section to document all other information pertinent to the assessment, treatment, and transport of the patient.*

7.2.5 **On-Line Medical Control (OLMC)**

A. **Time of Contact, OLMC Physician** – Document the time that OLMC was contacted and the ID number of the physician who was consulted.

B. **Reason for OLMC Contact** – Darken the appropriate box to indicate the reason for OLMC contact. Select only one reason.

C. **OLMC Terminate Time** – Document the time the resuscitation effort/CPR was ended as ordered by the OLMC physician.

D. **ED Chart Number** – Obtain and document the patient's ED chart number, especially when controlled substances have been administered.

E. **Controlled Substance Administration** – There are lines for documenting two separate controlled substance administrations.

NOTE: *Controlled substance administration must also be documented as a medication in the Flowchart section.*

1. **Crew #** – Document the number (#1 or #2) of the crewmember whose controlled substances are *administered* to the patient.

2. **C.S. Administered By-Signature** – The crewmember whose controlled substance was administered to the patient must sign in this area. This shall be the same crewmember whose number (1 or 2) is in the previous field.

3. **Witness Signature / Title** – Obtain the signature and title of the person who witnesses the *waste* of any unused controlled substance. This cannot be the same person who signed for administering the controlled substance.

4. **Amount Used** – Leave this section blank. Members shall document the amount of controlled substance used in the Flowchart.

5. **Amount Wasted** – Document in milligrams (mg), the amount of controlled substance that was not used and was discarded. Fractional amounts are rounded up to the next whole number.

6. **# Vials** – Document the number of vials opened and/or used in treating the patient.

7. **OLMC Physician** – Document the ID number of the OLMC physician who ordered the use of the controlled substance.

8. **URN** – Document the Usage Report Number (URN) assigned to the controlled substance by OLMC including the appropriate prefix and number. Administrative codes shall be documented in the 'Narrative History & Comments' section.

9. **SO** – Darken this box if the controlled substance administration was given via a Standing Order.

10. **S** – Darken this box if a seal is broken on a controlled substance but no medication is given during the treatment of the patient.

7.2.6 **Payer Info –** The ePCR is a patient care record and a billing document. Members shall make all reasonable attempts to fill in all appropriate areas in this section without delaying patient care and/or transport or returning to an available status.

NOTE: *Members must ask for medical insurance identification information (e.g., Medicaid/Medicare Card, commercial insurance card) from the patient or family member and document such in the appropriate area on ePCR.*

A. **Insurance Company Name** – Document the name of the patient's personal health insurance company, other than Medicare or Medicaid in this area (i.e., GHI, HIP, AETNA).

B. **Policy Number, Group Number** – Document the patient's alpha/numeric insurance policy and group numbers, if applicable.

C. **Insurance Related Information** – Darken the appropriate box indicating the type of insurance that applies to the patient based on the information received from the patient or other responsible adult.

1. Auto Insurance – For MVAs darken this box and document the patient's auto insurance company name and policy numbers in the appropriate areas (e.g., ALLSTATE, GEICO, PROGRESSIVE).

2. Self Pay – If the patient has no form of insurance, darken this box and leave the 'Insurance Company Name' blank.

3. Private Insurance – Document the name of the patient's personal health insurance company, other than Medicare or Medicaid in the 'Insurance Company Name' area (i.e., GHI, HIP, AETNA).

4. Work Related – Darken this box to indicate whether the illness / injury was work related.

D. **Medicare #, Medicaid #** – Document the patient's Medicare and/or Medicaid number in the appropriate boxes if the patient receives these benefits. Ask to see the patient's Medicare/Medicaid card, if applicable.

7.2.7 **Patient Acknowledgements and Releases** – This section is used in conjunction with the Patient Information Copy sheet that is given to each patient. A Spanish translation of each of the signature releases appears on the back of page 2. Fold the page down to the beginning of the Signature Section to display the Spanish translation to the patient. Take note that the sections and translations are numbered to correspond to each other.

A. **Patient Information Disclosure and Assignment of Claim** – This section **must** be completed whenever any patient is assessed and/or transported, including patients who refuse medical attention. Review the *Patient Information Disclosure and Assignment of Claim* information on the Patient Copy (green copy) of the ePCR with every patient.

NOTE: *Members shall have all patients sign in box (1) of the Signature Section to acknowledge receipt of the patient information disclosure (green copy) which is reviewed with and given to every patient including those refusing medical attention (RMA).*

1. Every patient is to be given the Patient Information Copy (green copy). After reviewing the information with the patient, have them or a guardian sign the *"Information Release Patient/Auth. Rep. Signature"* section in box (1) on page 2 of the PCR. If the patient refuses to sign, darken the box and leave signature box (1) blank.

2. When the patient is unable to sign the form due to their physical and/or mental condition, status as a minor, or emergency needs; and a guardian, representative, adult relative or other adult designee arranging treatment or exercising responsibility for the patient's affairs is present, have that designee read and sign as the authorized representative in this signature box. If this person refuses to sign, darken '*Patient Unable to Sign*' and sign your name in signature box (1).

NOTE: *Personnel shall inform the patient or his/her designee that their failure to sign the form will result in the patient being billed directly for services rendered.*

B. **Out of Area Transport/Diversion** – This section is used when a patient requests to be transported to a hospital that is outside of the Ten-Minute Rule or insists on being transported to a hospital that is on diversion.

1. Review the Out of Area Transport information with the patient and enter the name of the requested hospital in the appropriate box. A Spanish translation of this release appears on the back of page 2. Fold the page down to the beginning of the Signature Section to display the Spanish translation to the patient.

2. Have the patient sign his or her own name inside box (2) *"Out of Area Transport Patient Signature"*. If the patient is unable to sign or refuses to sign, darken the appropriate box and leave the signature box (2) blank.

3. When the patient is unable to sign due to his or her physical and/or mental condition, status as a minor, or emergency needs; and a guardian, representative, adult relative or other adult designee arranging treatment or exercising responsibility for the patient's affairs is present, have that designee read and sign as the authorized representative in this signature box. If this person refuses to sign, darken the '*Patient Refuses to Sign*' and leave signature box (1) blank.

C. **Release/Refusal of Medical Assistance (RMA)** – If the patient is competent and refuses medical care and/or transport to the hospital in accordance with the FDNY policy and procedure for Refusal of Medical Aid, darken the appropriate box and have the patient sign the '*RMA Patient Signature'* box (3).

2. If the patient refuses medical care and/or transport, have the patient sign his or her own name inside box (3) *'RMA Patient Signature'*. If the patient is unable to sign, darken the box and leave the signature box blank. If the patient refuses to sign, darken that box and print the name of the person (PD, family member, bystander, crew) who witnessed the patient's refusal to sign in the *"Patient Refused to Sign RMA – Witness"* box.

3. If the patient is transported to the hospital but has refused a specific prehospital treatment or procedure (e.g., oxygen, immobilization), have the patient sign his or her own name in box (3) *RMA Patient Signature* and darken the box indicating that the patient refused specific prehospital care and enter that procedure in the space provided.

D. **Hospital Receiving Agent Signature** – Obtain the signature of the person taking responsibility for the patient at the hospital. Only the Unit that physically transports the patient to the hospital is to obtain this signature.

1. Assisting units shall **not** obtain the Hospital Receiving Agent signature, but shall indicate the transporting unit's number and ePCR number in the 'Hospital Receiving Agent' signature area.

2. The Hospital Receiving Agent signature must be obtained prior to the Unit leaving the Emergency Department (ED). Personnel who experience delays in obtaining the Hospital Receiving Agent's signature shall contact the Emergency Medical Dispatcher and request an EMS Officer.

NOTE: *The Hospital Receiving Agent's signature only documents the name of the person the patient was turned over to in the Emergency Department (ED). The signature is not an indication of the quality of care or documentation.*

E. **Technician Signature** – The crewmember who documented in the 'Narrative History & Comments' section shall sign in this box.

7.2.8 **Safety**

A. **Lights / Siren** – Darken the appropriate box to indicate if lights and sirens were used while responding to the scene and/or to the Hospital Destination.

B. **Conditions Delaying Delivery** – Darken the appropriate boxes to indicate any condition experienced beyond normal parameters, that delays the crew from getting to the scene, patient and/or hospital.

C. **Seat Belt Use** – Darken the box to document the type of seat belt used by the patient. If no seat belt was used, leave blank.

D. **Car Seat** – Darken the box to indicate the type of car seat present, if any.

E. **Airbags Deployed** – Darken the appropriate box to indicate which airbags were deployed within the vehicle, if any.

F. **Patient Safety Equip.** – Darken each type of safety equipment used by the patient (e.g., if a construction worker got hit in the head while wearing a helmet, darken 'Helmet').

7.2.9 **Disposition**

A. **Removed to Vehicle By** – Darken the appropriate box to indicate how the patient got to the ambulance.

B. **Transported From** - Darken the appropriate box to indicate from what location the patient was transported.

1. **Residence** (Home) – Includes apartments, boarding houses, private homes, noninstitutional places of residence, private driveways, private garages, private gardens, private walkways, swimming pools in private gardens, and the yard of home.

2. **Scene of Accident or Acute Event** – Public areas, streets, highways, public buildings, police precincts, schools and office buildings.

3. **Residential, Custodial Facility** – Dormitory, hospital, home for elderly (e.g., assisted living, single room occupancy facility), orphanage, correctional institutions, reform schools and homeless shelters.

4. **Skilled Nursing Facility** (SNF) – A facility, typically a nursing home, which meets specific regulatory certification requirements, and primarily provides in-patient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

5. **Other** – FDNY does not currently use this field; therefore this box should never be darkened and the *Transport From Code* boxes shall be left blank.

C. **Transport Position** – Darken the position in which the patient is placed during transport *(choose only one).* Darken the 'Restrained' box only if the patient was restrained during transport.

D. **Pt Transported By Vehicle** – Members shall use this section '*only*' if the Unit completing the ePCR actually physically transports one or more patients in their vehicle. All other dispositions are documented in the 'Patient Not Transported By Vehicle' section.

1. **No. of Patients Transported by This Vehicle** – Document the number of patients physically transported from the scene in the Unit's vehicle.

2. **Hospital Destination** – Document the destination Hospital's ID number.

3. **Transported to Morgue** – Darken the box to indicate whenever a Unit transports to the morgue (10-82 M). The carbonless copy of the ePCR (pages 1 & 2) shall be given to the morgue attendant. The morgue attendant is required to sign in the *Hospital Receiving Agent* signature area.

a. If this box is darkened to indicate transport to the morgue, the appropriate destination number from the reference sheet shall be documented under '*Hospital Destination*'.

E. **Hospital Selection** – Darken the appropriate box to indicate hospital selection.

1. **Nearest Facility** – The closest appropriate hospital destination located geographically in accordance with the Ten-Minute Rule. A patient in stable condition, upon request may be transported to an alternate 911 Hospital Destination, provided it is no more than 10 minutes additional travel time from the scene than the closest 911 Hospital Destination. This shall be documented as the nearest facility and not as patient choice.

2. **Patient/Family Choice** – The hospital that the patient is transported to by either his/her/family/physician request, when the facility is more than 10 minutes additional travel time than the nearest 911 Hospital Destination or if the facility is not designated as a 911 Hospital Destination. A patient in stable condition, upon request and execution of a release form and with prior approval from OLMC, may be transported to an alternate facility.

3. **Specialty Referral** – The hospital that the patient is transported to based on the patient's particular special needs (e.g., burns, trauma). Patients who meet the criteria for a specialty referral shall be transported in accordance with Department policy and procedures.

NOTE: *If a Specialty Referral Center falls within the Ten-Minute Rule, the disposition is documented as 'Nearest'.*

4. **Hospital Diversion** – When a patient asks to be transported to a hospital that has requested that ambulance patients be transported to another facility. Although the hospital emergency department is not closed, the facility is unable to handle additional patients.

   a. If this box is darkened to indicate transport to a facility that is currently on diversion, the name hospital requested by the patient must be entered in the *Hospital Requested* box in the *Out of Area Transport / Diversion* section (2).

5. **Diverted From Code** – Document the Hospital ID code for the hospital from which the Unit was diverted.

F. **Patient Not Transported By Vehicle** - Darken the appropriate box to indicate a patient's disposition when the unit does not transport the patient in their vehicle. Appropriate copies of the assisting unit's ePCR shall be left at the hospital for inclusion in the patient's hospital record.

NOTE: *Members shall use this section to document <u>all</u> instances when the Unit assists in the assessment and/or treatment of a patient, but does not physically transport the patient in their vehicle.*

1. **Assisted in Transport with Unit # -** Darken this box if the Unit assisted in the assessment and/or treatment of a patient. Document the transporting unit number on the line provided.

2. **RMA** – Darken this box if the assisting Unit did not transport because the patient refused medical attention. If this box is darkened, the *RMA Patient Signature* box (3) and the *Information Release Patient/Auth. Rep. Signature* box (1) must be completed.

3. **Pronounced on Scene** – If the patient is pronounced dead at the scene and left in the custody of the Police Department (10-83), the carbonless copy (pages 1 & 2) shall be given to the Police Officer on-scene. The ePCR must be completed prior to leaving the scene and no comments may be added after leaving the scene.

4. **On-Scene Triage** – If a patient is refused transport to a hospital, review the *On-Scene Triage Notice* section on the Patient Copy (green copy) of the ePCR. Document the Date, CAD number and Unit number where appropriate on the Patient Copy prior to giving to the patient and have him or her sign their own name in box (1) of the signature section on page 2.

5. **Transferred Care To Unit #** – Darken the box to indicate that care of a patient was transferred to another Unit. Enter the Unit number to which patient care was transferred.

6. **Other** – If this box is darkened, document the reason in the 'Narrative History & Comments' section.

7.2.10 **Admin** – This section and the data fields will be used by EMS Operations and Office of Medical Affairs for special data collection projects. Units shall use this area only when and as directed.

7.3 Completing Patient Copy (Green Sheet)

7.3.1 **Patient Copy** – This sheet is torn out and given to <u>every</u> patient, whether transported or not. It provides an explanation of the Notice of Privacy Practices and Patient Information Release/Assignment of Claim. After appropriate sections are explained to the patient, give it to them for future reference. For ease of use, the statements are printed in English on the left and Spanish on the right half of side of each page.

NOTE: *All patients must sign in box (1) of the signature section on page 2, to acknowledge receipt of the Notice of Privacy Practices and Patient Information Release.*

7.3.2 **Patient Information Disclosure and Assignment of Claim** – The front side of the page is reviewed with every patient prior to their signing box (1) on page 2.

7.3.3 **Special Patient Information Disclosure** – This side details explanation for the patient on the Refusal of Medical Assistance, Out of Area Transport/Diversion, On-scene Triage and Health Insurance Information. This information is reviewed with every patient prior to their signing the required boxes on page 2.

A. **Refusal of Medical Assistance** – This section must be reviewed with patients that have refused required medical assistance **before** they sign in box (3) of the signature section on page 2.

B. **Out of Area Transport/Diversion** – This section must be reviewed with patients that have requested to be transported to a hospital that is more than 10 minutes away from the closest one or one that is on diversion status. After reviewing with the patient, have the patient sign his or her name in box (2) of the signature section on page 2.

C. **On-scene Triage Notice** – This section must be reviewed with patients that have been assessed and/or treated but will not be transported to a hospital. On-scene triage of patients requires OLMC approval. In all cases, the *On scene Triage* box under *Patient Not Transported By Vehicle* in the Disposition section of the ePCR shall be darkened.

1. Document the Date, CAD number and Unit number on this page prior to giving to the patient and have the patient sign to acknowledge their receipt of the Notice of Privacy Practices and Patient Information Release in box (1) of the signature section on page 2.

BY ORDER OF THE FIRE COMMISSIONER AND THE CHIEF OF DEPARTMENT

EMSC OGP 102-06, ADDENDUM C
JULY xx, 2004

LIFEPAK 12 AND ePCR INTEGRATION

1. PURPOSE

1.1 To set forth the policy and procedure for integrating LifePak 12 (LP 12) data with the electronic Patient Care Report (ePCR), and to transfer data electronically to the designated computer in the Battalions.

2. SCOPE

2.1 This procedure applies to all FDNY EMS Paramedics.

3. OVERVIEW

3.1 The EKG created by the LP 12 is an essential part of a patient's medical record. As the FDNY implements the ePCR, EKGs will need to be electronically linked and archived with the ePCR file.

3.2 To accomplish this, the LP 12 must be connected to the designated computer in the Battalions using a data transfer cable, and the data on the LP 12 must be downloaded ***prior*** to scanning ePCRs.

3.3 Upon completion and confirmation of the data transfer, the Crew must delete all of the records stored in the LP 12.

4. DEFINITIONS

4.1 **Electronic Prehospital Care Report (ePCR)** – The official, legal record of patient contact and of care provided.

4.2 **Data Transfer Cable** – Allows the transfer of data from the LP 12 to the designated computer in the Battalion. The cable is always left attached to the Battalion computer.

4.3 **Data Transfer (DT) Express** – Software installed on the designated computer in the Battalions that facilitates the data transfer from the LP 12.

5. POLICY

5.1 Members **shall not turn off** the LP 12 for any reason while treating the patient. If the LP 12 must be separated from the patient for any reason, (e.g. patient movement) paramedics shall disconnect the patient cables from the LP 12 until the cables can safely be reconnected. At no time during the treatment of the patient should the device be turned off. The LP 12 may be turned off between patients.

5.2 During the treatment of a patient when the LP 12 is used, the member shall enter specific patient identification data and the ePCR number into the LP 12 while at the patient's side. Patient care and transport **shall not** be delayed while recording this data.

5.3 Upon the completion of each tour, the paramedic assigned as the Technician shall bring the LP 12 to the designated computer in the Battalion and transfer data from the LP 12, prior to scanning and analyzing the ePCRs.

5.4 If for any reason the LP 12 goes out of service (i.e., device breaks, LifePak failure, expired maintenance tag) during the tour, perform all data uploads and transfers prior to placing the LP 12 off service.

5.5 Paramedics shall not alter, edit, update or change, in any way, any Medical Equipment Unit (MEU) preset settings on the LP 12.

5.6 Upon completion and confirmation of upload and data transfer, the paramedic shall delete all data stored in the patient archives on the LP 12.

6. PROCEDURE

6.1 Entering Patient Information

6.1.1 While at the patient's side, members shall turn the LP 12 on and press the **OPTIONS** button and select **Patient** by pressing the Selector dial.

6.1.2 Select **Last Name** by pressing the Selector dial and enter the patient's last name in the **Last Name** field by rotating the Selector dial, then pressing the dial once the desired character is highlighted. Once the patient's Last Name has been entered, select **End** to return to the Options/Patient screen.

6.1.3 Turn the dial until **Incident** is highlighted and press the dial to select it. Enter the ePCR number in the **Incident** field by rotating the Selector dial to highlight the desired character, then pressing the dial to select that character. Once the Incident (ePCR) number has been entered, press the **Home Screen** button and continue to provide patient care.

6.2 Transferring the data

6.2.1 On the designated computer in the Battalions, members shall double-click the DT Express icon to open the data transfer program and then click on the **QUIK-STEP** button to launch the Download Wizard and prepare it to receive data. DT Express is now ready to receive the LP 12 data.

6.2.2 On the LP 12, members shall:

A. Connect the LP 12 unit to the PC using the cable attached to the back of the designated computer in the Battalions.

B. Turn the LP 12 on and press the **OPTIONS** button.

C. Select **Archives** and select **Yes** to enter the patient archives.

D. Select **Send Data**. The Patient, Report, Site, and Prefix are preset by MEU and shall not be changed by the Members.

E. Select **Send** to begin transferring all patient records to the designated computer.

6.2.3 After all of the patient records have been transferred, the DT Express program will show the status of the data transfer on the designated computer. Once all selected records are done being transferred, click on the **Next >** button and the Data Entry screen will open.

6.2.4 Members shall ensure that the Incident number previously entered is the exact same number as the corresponding patient's ePCR number. Members shall use the Last Name field to help confirm they have the correct ePCR and patient. If the numbers are not the same, Members shall update this information in the computer.

A. If there is more than one LP 12 record, click the **Next >** button to accept the values on the current record and go to the next record.

B. If the current record is the last record, click **Finish** to begin transferring the data.

6.2.5 If all of the patient records have successfully been transferred, the DT Express program will show ***** FINISH ***** on the last line of the *Case Auto Complete* dialog box.

6.2.6 Once all of the records have been transferred, click on the **Close** button. The *Case Auto Complete* dialog box will close and return you to the DT Express window. Close the DT Express program by clicking on the **Exit** button in the upper right corner.

6.3 Deleting the patient data

6.3.1 On the LP 12, Members shall:

A. Press the **Home Screen** button to return to the Options/Archives screen and select **Delete**.

B. On the next screen, select **Delete** to delete the information of the patient displayed. Continue to select **Delete** until all patient records have been deleted.

C. Turn the LP 12 off and disconnect the cable from the back. Members shall then proceed to scan the ePCRs.

BY ORDER OF THE FIRE COMMISSIONER AND THE CHIEF OF DEPARTMENT

DRAFT

EMSC OGP 102-06, ADDENDUM D
July xx, 2004

TRANSFERRING DATA FROM THE LIFEPAK 12

I. Transfer the data

On the PC desktop,

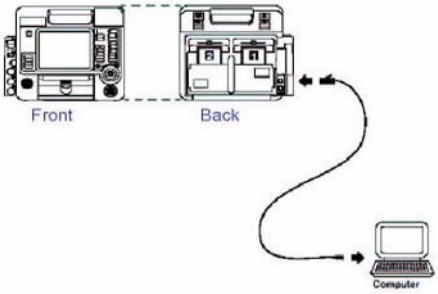
1. Double-click the DT Express icon to open the data transfer program

2. Click on the **QUIK-STEP** button to launch the Download Wizard and prepare it to receive data

3. DT Express is now ready to receive the LIFEPAK 12 data.

On the LIFEPAK 12,

4. Connect the LIFEPAK 12 unit to the PC using the cable attached to the back of the PC

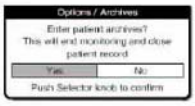


5. Turn the LIFEPAK 12 on

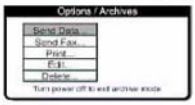
6. Press the **OPTIONS** button

7. Select **Archives…**

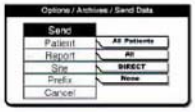
8. Select **Yes** to enter the patient archives



9. Select **Send Data…**



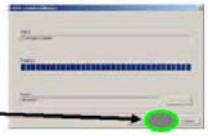
10. Select **Send** to begin transferring all patient records to the PC.
    - The Patient, Report, Site, and Prefix should be preset for you



On the PC,

- The DT Express program will show the status of the data transfer

11. Once all selected records are done being transferred, click on the **Next >** button and the Data Entry screen will open



12. Make sure the Incident number is the exact same number as the patient's ePCR number.
    - Use the Last Name field to help confirm you have the correct ePCR and patient

13. If there is more than one LIFEPAK 12 record, click the **Next >** button to accept the values on the current record and go to the next record

14. If the current record is the last record, click **Finish** to begin transferring the data.